MONTANA
Department of Public Health & Human Services

February 2002

Medicaid Form Order

Copy and complete this form, and mail to the address below or fax to (406) 442-4402. Please allow three to four weeks for delivery. These forms (and others) are also available on the Provider Information website (see *Key Contacts*) and in most Medicaid billing manuals for your provider type. To obtain CMS-1500, UB92, or universal pharmacy claim forms, contact a printing and publishing company. To obtain ADA dental forms, call (800) 947-4746.

Montana Medicaid
P.O. Box 8000
Helena, MT 59604

Montana Medicaid **Date** _____

MEDICAID FORM ORDER

Form Name	Quantity	Form Name	Quantity
Pharmacy (MA-5)		Hysterectomy Form	
Nursing Home (MA-3)		Sterilization Consent Form	
Dental P.A. Request (MA-4PA)		Eligibility Inquiry Form (SRS-456)	
Adjustment Form		Abortion Certification (MA-037)	
Claim Inquiry Form			

Provider Information
Provider Number: _____
Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Return Form To:
Montana Medicaid
P.O. Box 8000
Helena, MT 59604